DOCUMENT RESUME

ED 103 742 CG 009 611

AUTHOR LeUnes, Arnold
TITLE The Delivery of Mental Health Services in Small Communities: An Experimental Model.
PUB DATE May 74
NOTE 18p.; Paper presented at the Annual Meeting of the Southwestern Psychological Association (22nd, El Paso, Texas, May 1974)

EDRS PRICE MF-$0.76 HC-$1.58 PLUS POSTAGE
DESCRIPTORS *Community Action; *Delivery Systems; *Mental Health Programs; *Models; Program Descriptions; Program Planning; Speeches; *Success Factors

ABSTRACT

A model for the delivery of mental health services to people residing in small communities (less than 10,000 population) is presented. The model is the product of personal consultation experience over the past three years with a modestly staffed and financed but very successful mental health agency. Emphasis is placed on community action, political and financial autonomy insofar as possible, economy, intelligent use of paraprofessionals, and the careful hiring of permanent and consultative staff. In essence, it is the creation of a general model based on the success of one specific agency which epitomizes the points previously emphasized. (Author)

ED103742

The delivery of mental health services in small communities: An experiential model

Arnold LeUnes

Texas A&M University

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

The provision of mental health services at the community level is a reasonably recent innovation. Perhaps it is equally safe to say that an even more novel undertaking is the delivery of services to the citizens of small communities. Segal (1973), among others, draws special attention to the latter problem. At the same time, he makes particular mention of five specific programs in four states with recent annual budgets ranging from $400,000 to $1,400,000 that are responsible for mental health problems in rural areas. It is presently contended that the provision of these services is essentially but not entirely a community matter, that it can be done with a minimum of staff and facilities, and that it can be done without excessive expenditures of money. A case in point is the Brenham-Washington County Counseling Service, located in Brenham, Texas. The model it provides is a rather simple but successful one, and it can be implemented with minor local adaptations to serve the mental health needs of people living in small communities. Three years of close personal involvement as consulting psychologist for the agency has convinced me that its simplicity and success represent ideals that should serve as impetus for leaders in small communities to institute similar services. In a country and era where being big is often equated with being good (and our current approach to establishing community mental health centers seems to be a case in point), there is evidence that

CG 009 611

being small, simple and successful is not impossible or incompatible and it may even be preferable!

The Setting

Brenham, Texas, the county seat of Washington County, is located in the east-central part of the state. The city has slightly less than 10,000 citizens, and the county has approximately 20,000. Both the city and county have a high proportion of black people, though there has been a fairly recent but continual movement away from the rural areas to the city on their part. Prior to this trend, the city itself was almost exclusively made up of people of German or Polish descent, primarily the former. Still today, many older German and Polish traditions are observed.

Economically, the city and county are rather depressed. For the county as a whole, just a quick listing of recent data should paint a fairly clear picture of the situation:

1. Slightly over 50% of the families have a yearly income of $3,000 or less.
2. One-seventh of the total income is medical or public assistance based.
3. One-eighth of the families are on food stamps.
4. One-sixth of the population is over 65, but nearly half of the male heads of household are over 65.

The picture, generally, is one of an aged population, low income, and concomitant deprivation.

Educationally, the picture is equally striking. Only four out of ten who begin school in the county ever graduate from high school, and the median years of school completed is 7.7 (as opposed to 10.4 for the state as a whole).

Other miscellaneous indicators of the problem include the fact that 10% of the homes still are heated by wood stoves and 4% still have outdoor toilet facilities. A final point of concern is the fact that only 1/3 of the children arrive at the first grade of school with immunization against the various communicable diseases.

With these conditions of general deprivation in mind, several other things are underfoot that are conducive to social change and unrest, and result in emotional problems. One of these is the continually creeping influence of "outsiders" in the community. The state capital, Austin, is 90 miles away in one direction with Houston on the other end of the connecting highway at about the same distance. Though somewhat distant, real estate investors, retired people, professional people seeking weekend retreats in the country, and similar types are increasingly making inroads on the previously insular way of life the citizens enjoyed. Too, a new state school for the mentally retarded has recently opened its doors. With it came a cadre of outside people, though this is somewhat counterbalanced in the economic sphere by its pumping approximately 3 million new dollars annually into the county income. In any case, a slowly shifting powers base made up of "outsiders" is creating changes in many spheres. The decline of agriculture has been an influence, also. Men who previously worked a living from the soil are now forced to work at things less prestigious and profitable. A third intangible is a gradual loss of "old-country" traditions. Slowly but surely the old ways are dying.

With these factors in mind---a county and city in transition, an aging population, a low economic base, and low educational attainment---it is no surprise that mental health problems are in abundance. And this is when and where the need for mental health services at the local level becomes

glaringly apparent. It is doubtful that Brenham and Washington County greatly differ from many areas of similar make-up in this country, and it probably has no more or no less problems than any other. But it is an area that chose to do something about it with as few outside resources as possible; hence, the creation of the Brenham-Washington County Counseling Service (BWCCS).

The Services

Early in 1968, a group of concerned citizens, primarily ministers, met in an effort to find ways of dealing with problems beyond the scope of existing resources. From the meeting, the BWCCS was created, and modest funding was appropriated from the United Fund, the Lutheran Social Service, Washington and Burleson County Medical Services, the Hogg Foundation for Mental Health of the University of Texas, and the Texas Department of Mental Health and Mental Retardation.

Initial staffing was done through a social work intern from the University of Texas School of Social Work. Until the end of 1968, 135 people were interviewed and some form of therapy was instituted for 42 of them people. In April of 1969, the Texas Department of Mental Health and Mental Retardation started referring mental patients from this geographical area who were discharged from the Austin State Hospital to the service. To meet an immediate increase in patient workload, a case worker was employed. He, too, was a social work intern and today serves in the capacity of Director of the agency. As of July of 1969, services were available Wednesday through Friday of each week. This soon was recognized as insufficient and in September of 1970, a full work schedule was implemented under the Director/Social Worker and a full-time Secretary/Case Worker Aide. By this time there were 250 people in need of the services of the agency. The offices were set up in an old boutique,

just to the side of the main part of town, and this facility served as the base of operation until March of 1974.

One initial problem, and one that all should recognize, was that of selling the service to the community. There was a certain amount of skepticism and apprehension with the existence of such a facility, and it became a service of interest (some morbid) to passers-by. The maturity of the director (a retired military man), his background (raised in German areas of Wisconsin, and of German name and descent), and his linguistic ability (speaks German fluently) all served him well, and made for easier entry into a community in which the power structure is almost exclusively of German descent. Having such a combination of traits is certainly not something that can be tailor-made for each individual situation, but it does point up the importance of careful selection of staff. Having a man of such qualifications was a blessing at the time, and served the agency well in its efforts to amass greater community support.

Another very helpful step was the creation of a broadly-based Board of Trustees, a board that was involved then in a meaningful way and one that remains so today. Though too large some would say, it was felt that this provided a broad base for involvement within the board and outside in the community. The original board was essentially a cross-section of the community and differed little in make-up from the present one which is made up of a physician's wife as president (past chairmen have been various ministers), businessmen, nurses, physicians, and other concerned citizens.

By the end of 1971, the patient load had grown to well over 250. New measures became necessary as a function of the growth. 1972 ushered in the "modern" era, and many new programs were to be developed in an effort to deliver more effective services.

The Past

In January, 1972, through additional funding provided by the Texas Department of Mental Health and Mental Retardation, an approach to delivery emphasizing a consultation modality was begun. Two local physicians representing each of the local clinics were hired to come in on every other Thursday afternoon for clinic. This gave the physicians a chance to look in on many of the poorer, older, or less often seen clients for purposes of reviewing medications checking physical complaints, and engaging in related activities. Later, a consulting psychiatrist was hired to come in once a month to deal with medications, make recommendations on particularly difficult cases, and conduct other business appropriate for such a practitioner. These services were provided through an arrangement with the Austin State Hospital, and consisted of sending a resident down to the agency. This activity continued until recently, but was discontinued due to greater accessibility to psychiatric services in the area.

A final and more far-reaching consultative service came about when I was hired as the consulting psychologist. The initial agreement was to employ my services two afternoons per week, and that same relationship continues today. It became obvious within weeks that, though the multiple additions to the staff were helpful, they were going to be insufficient at best. This led to the beginning of a program of immense success, not unexpectedly, and this was the inclusion of college students as paraprofessionals. Prior experience had indicated that the availability and the trainability were there. This has been beautifully pointed out by Lunneborg (1971) and Durlak (1973), among others.

The paraprofessional group deserves special mention because of their immense contribution to the success fo the overall agency treatment program. They were initially received with a certain amount of skepticism due to their

age, inexperience, lack of "professional" credentials, and a host of other reasons ala those pointed out as myths by Durlak. The hair tended to be longer and the dress more casual than that of the populace, but these barriers soon were broken down. As of this time, there have been 22 students working for as little as one academic semester and as long as two years (10 males and 12 females; 15 undergraduates and 7 graduate students; average work 6 1/2 months). They have worked with chronic schizophrenics, alcoholics, delinquents, neurotics, the aged, children and adolescents, and the mentally retarded. Some have charged that they are given cases above and beyond their training and capabilities. There is evidence that this is a myth (Durlak, 1973), and certainly is preferable to the response by one traditionally trained clinician who recently chastized me verbally by stating that "seniors in psychology should be allowed to do nothing more complex in a mental health setting than answer the phone." In any case, their work is steady, productive, and a source of pleasure to those who supervise them.

One interesting sidelight of the student program is the summer internship provided for one of the graduate students. This is a 3/4 time position with excellent pay, much responsibility, and tremendous personal and professional growth. The three holders of the position to this point have been remarkably professional, personable, and productive.

At the risk of going on forever about the work of these 22 people, suffice it to say that they are a most important ingredient in the present model.

The Present

1974 finds the agency staffed by a full-time Director/Social Worker, a Secretary/Case Worker Aide, a one day per week consulting psychologist,

two consulting physicians, a licensed vocational nurse (family planning), a summer intern, a high school student who works each afternoon for academic credit, an occupational therapist, several local volunteers, and five undergraduate psychology students. Plans for an additional case worker are underway, but are in the preliminary stage at this point.

Services provided include the usual types of therapeutic activities provided by most of the staff in one way or another; that is, home visits, one-to-one counseling/psychotherapy, etc. In addition a sheltered workshop for mentally retarded individuals is partially administered by the agency and employs two people. Too, a workshop for other individuals has recently become operational through a developmental disabilities grant, and 15 people are served here. A thrift shop largely operated through gifts of clothing and other items is operational, and profits gained there are applied back as incentive pay for clients in the workshop. A working relationship with larger facilities, the Central Brazos Valley Mental Health Center in Bryan, Texas, and the Austin State Hospital, adds a new dimension in areas where emergency services and/or hospitalization become necessary. A small living-in arrangement in the agency has also recently opened to handle cases where hospitalization is not necessary but separation from negative people or conditions is. Family planning for the county is housed in the agency, as are the services of the local Red Cross. Finally, retardation services are provided in cooperation with the newly opened state school in the city.

According to June, 1974, figures from our files, the patient load has stabilized at 253 people, 162 being female and 91 males. 194 are Anglo and 59 black. The largest diagnostic group is neuroses (47), followed by

transient situational personality disorders (45), retardation (20), and psychoses (16). Interestingly enough, not one file is active on narcotic abuse at this time. Hospital admissions from the county have declined over the last three years, showing 37 admissions in 1971, 17 in 1972, and 20 in 1973. Projections for 1974 show an expectation of 9 hospitalizations.

The Future

The most immediate event is an upcoming restructuring of an administrative type, and will require that the agency be administered by the Brazos Valley Board of Trustees in Bryan, Texas. The larger agency is responsible for providing mental health services for a surrounding seven county area. It appears that this change will have minimal impact in that the agency is on-going, whereas there is much to be done in the other six counties. In any case, it is not anticipated that far-reaching changes are to be made due to realignment administratively.

Additional work in alcoholism should be a goal for the near future, and efforts are underway to provide more services in the future. However, the plans are only tentatively stated at this time. The need is there. Hopefully, the services will be soon.

With the provision of services stabilizing to a fair degree, the time for evaluation and research has arrived. A preliminary investigation conducted recently in which clients responded to questions about the availability and quality of services seemed to indicate that both are there, but more can be done. Though helpful, a much more sophisticated appraisal system needs to be developed and efforts are underway to accomplish this goal.

Another area of concern is publicity and public relations. It is believed that the present product is good and deserves mention to interested

parties. Considerable effort is underway and will continue in earnest to "toot our own horn" a bit.

A projected undertaking, in preliminary form, is to establish a monthly guest speaker program on topics of interest to mental health professionals and concerned laymen. This proposal is designed to enhance understanding and create and reinforce favorable attitudes toward mental health efforts.

With an aging population, it is not surprising that nursing care facilities are numerable in the area. As the provision of services to these citizens becomes more social/psychological in nature, it is anticipated that much of the effort can be provided through our auspices. Some cooperation is already in existence, but should become more salient with the passing of time.

Other things are in the think stage and will merit more serious consideration in the future. In any case, growth has been continuous, steady, and at a rate that is manageable. Generally the future looks as exciting as the past has been.

The Model

Based on the preceding experiences, a model for delivery of basic services in small cities (less than 10,000 residents) would look like the following:

I. Budget

A. $35,000.00

(a) Director, $15,000.00

(b) Secretary/Case Worker Aide, $5,000.00

(c) Consultant Fees, $7,500.00

(d) Overhead Expenses, $7,500.00

Though listed at $35,000 it may be possible to cut here and there and get by for less. An absolute minimum would be $25,000 with serious but judicious cutting. It may be naive to think that even $25,000 is possible with all the demands on community financial resources. However, it can be done with little or no outside funding. The old adage, "Where there's a will, there's a way" is most applicable here.

II. Staff

A. Director

Extreme care must be exercised in the selection of this individual as he makes or breaks the agency by what he does or doesn't do. His training should be such to enable him to function in a broad spectrum, and his personal characteristics should be such that they inspire confidence and support of all with whom he interacts. This person should have advanced training in the area of psychology or social work, though it is not mandatory at all that the Ph.D. degree be required.

B. Secretary/Case Worker Aide

This individual is so key to the success of the operation that the selection process should be as stringent as possible here. Perhaps the main public relations person for the agency, this person must meet people easily, with courtesy, and professionally. She should be truly interested in people, should be capable of extreme caution in terms of secrecy, and should be an anchor for all to tie to. She must be capable of working with the professionals, paraprofessionals, and board members with whom she must constantly interact. (Enough cannot be said about our present secretary. She gives yeoman service, and in every way exceeds the qualifications stated here. She definitely is a model to emulate with regard to this position).

C. Consulting Psychologist

This person should preferably have ties with a university for purposes of engaging graduate and undergraduate students in field experiences and research, for the research and consulting capabilities that would be accessible through him, and for other advantages that this relationship might provide. He should engage in some testing, some therapy, a good deal of supervision, and otherwise be an ideas man for public relations, grant proposal writing, and related undertakings.

D. Paraprofessionals.

The majority here should be the college students that would be closely tied to the consulting psychologist. The advantage of supervision of students makes them particularly valuable and reliable. Other volunteers should be chosen carefully and with the idea in mind that one or two good ones are far more valuable than a large number of unreliable and unsupervised bad ones! The value of good volunteers in terms of providing service, and who at the same time are learning and researching cannot be overestimated.

E. Consulting Physicians.

Depending on the local situation, these people should be brought in for an hour each week for purposes of prescribing or reviewing medications, hearing and (where feasible) treating minor complaints, and generally dealing with physical complaints that may arise that are hindering psychological and social therapy. Where possible, such as the local case, involving physicians from separate clinics has value in terms of spreading the involvement. Obviously, this will require adaptation, but involvement of the medical community in mental health work is most recommended.

F. Consulting Psychiatrist

In small communities, the likelihood that such people will be available is miniscule. However, contacts with a regional mental health center or near-by state hospital should turn up a good psychiatrist with an interest in community involvement. An every other week arrangement, perhaps a half-day, should be sufficient. His major role would be that of "trouble-shooter" on recent tough cases of all varieties, those with overriding physical symptoms, and those where physical causation (i.e., strokes) is a salient feature. Medications review, information on modern psychiatry, and public relations work would also be required of this staff member. Hopefully, he would be a person of some predictability vocationally, someone to provide continuity of care. A flaw in the present attempt was that the consulting psychiatrist was almost invariably an intern who was rotating through various services, one of them being our agency. This generally, was a most unsatisfactory situation. The clients were never able to identify with the psychiatrist and to some extent, the reverse was true! Affiliation with and belief in the agency is most important for all staff members!

G. Summer Intern

This highly-successful feature of the program should be instituted and maintained where possible. A second-year M.S. candidate or a doctoral student is preferable, and the capacity for independent action is of paramount importance. Aside from dealing with groups and individual cases, he serves as the "leader" during the absence of professional personnel. This allows the director to have release time, attend classes of interest when available, and otherwise engage himself in an oft-mentioned (and often forgotten) activity known as professional development. Thirty hours per week is recommended as a sufficient work period to guarantee maximum efficiency.

H. Miscellany

Other people presently on board in the present situation may be added to the model through local, state, or federal grants. This includes the family planning nurse and the full-time workshop director.

III. Facilities, Services, and Fees.

The first of these considerations is the least troublesome in that almost any facility will do. The old adage that "a fine stable doesn't make for fine horses" is applicable here. Certainly, no one would resent the maximum in facilities but most have no choice but to settle for less. In any case, a facility of sufficient size to provide, at the least, three counseling rooms would be recommended. Too, a quiet and hopefully private reception area could be provided. Above and beyond these, a room for paraprofessionals to spread out, rap, keep valuables, do paper work, and meditate would be extremely useful. Finally, an adjacent area for workshop activities, however large or small, would be a decided asset. Keeping in mind the relatively modest nature of the present model, this would seem to be almost a grandiose plan. Nevertheless, it is being done presently and can be done again.

Services by necessity will be more limited than is desirable. Generally, those available should include counseling, psychotherapy, crisis intervention, suicide prevention, home visitations, psychological testing, workshop activities, family counseling, marital counseling, and other related services.

Fees should be based on an ability to pay basis, and leniency should be the guiding principle. No one should be turned away for lack of money! Budgeting should reflect little reliance on this method of fund-raising. Though controversial, it is essential that services be provided, and it has yet to be clearly demonstrated that paying moderate to large fees facilitates recovery or remediation. One method of reaching certain clients with problems

amenable to paraprofessional skills is to assign the students to them minus any fees. Something for nothing is most erroneous here.

IV. Miscellany

The remainder of the model is one of subjectivity. Having fine facilities, much money, a variety of programs, and the other trappings guarantees nothing. So at the risk of being repetitious, the following suggestions are offered to cement the model together:

A. Select a good director. Find a man with his "heart in the right place." Our field, as does others, has a number of people who seem to be on an ego-trip, are empire-builders, or have other priorities ahead of the operation of the center. This cannot be if the model is to work.

B. Involve your Board of Trustees. These are key people and the value of their potential contribution is inestimable.

C. Involve your paraprofessionals. For the most part, this should be the college group, though concerned citizens can be very helpful here. However, a good paraprofessional program does not occur by chance. Much thought and work is necessary for this undertaking to succeed.

D. Know the community. An in-depth look at the finances, the mores and folkways, and other relevant sociological variables is also essential. The mental health professional who knows his community is well on the road to success.

E. Communicate with schools and other agencies. Try at all times to be on good working terms with all allied agencies with whom you and your clients might interact. Again, this is difficult but not impossible. And it is sometimes easy to overlook this point. The relationship cannot be taken for granted, and requires work. But your clients and agency will profit from a positive relationship among the various interacting agencies.

F. Maintain local autonomy insofar as possible. Few communities have the resources to completely finance a model of this magnitude, but reasonable local autonomy is possible. Every effort should be made to rely on local resources, and only when all else fails should outside help be sought.

G. Be flexible. New ideas, new problems, new treatment strategies, new demands, and new circumstances will arise. Flexibility and capacity for change are of the essence.

Summary

The preceding discussion, including the delivery model, has been generated through personal observation of and participation in an on-going and effective operation. It is admittedly a rather simple model, one devoid of unnecessary jargon, unproductive dogma, and professional jealousy, just as is the case of the agency operation itself.

Most important of all is the fact that the model can be implemented in small communities across the nation, but not without effort. Concerned citizens must band together in much the same way as did the people in Brenham, Texas, in 1968. Armed with interest, a few thousand dollars, and the present model, they will find that they too can offer first class mental health services to their citizenry!

References

Durlak, Joseph. Myths concerning the nonprofessional therapist. Professional Psychology, 1973, 4, 300-304.

Lunneborg, Patricia. Undergraduate psychology field work: The unwashed take over. American Psychologist, 1970, 25, 1062-1064.

Regional plan for drug abuse prevention and treatment. Bryan, Texas: Brazos Valley Development Council, 1974.

Segal, Julius (Ed.) The mental health of rural America. Washington: Department of Health, Education and Welfare Publication No. (HSM) 73-9035, 1973.